

DEMOGRAPHIC INFORMATION

Name _____ Today's Date _____
 Address _____ Employer _____
 City, State, Zip: _____ Type of work _____
 Email _____ If retired, what was your occupation? _____
 Phone (home) _____ (cell) _____ (work) _____
 Date of Birth _____ Age _____ Travel time to this office _____
 Gender: F M Other • Enrolled in Medicare? Height: ____ ft ____ in • Current weight: _____
 Marital Status: S M W D Partnered Lowest adult weight ____ Highest ____ Desired _____
 Name of Spouse/Partner _____ Medical Doctor _____
 Spouse's Occupation _____ Referred to our office by _____
 Name(s) and Age(s) of Children _____
 Other Household Members (include extended family, non-family and pets) _____

 Name of person responsible for payment of professional services _____
 Practitioners at the Lydian Center you have previously seen _____

CURRENT HEALTH REPORT

Please describe the principal health problems for which you would like to come to this office. Include approximate date of onset.

* Type: P=Pain; A=Ache; ST=Stiffness; N=Numbness; T=Tingling; S=Soreness; O=Other

** Pain: For each complaint, rate the level of current pain on a scale of 1-10. 1=no pain; 10=severe pain

<u>Principal Health Problems</u>	<u>Type</u> *	<u>Pain</u> **
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

What are your long-term goals in coming to this office? _____

How long has it been since you have felt well? _____

Are your present complaints due to an injury? no yes auto accident other _____

Is your condition getting progressively worse? no yes • Pain is: constant comes and goes

Is your condition interfering with your: work sleep daily routine other _____

Have you lost any days of work? no yes Dates _____

What activities aggravate your condition? _____

What makes it feel better? _____

Have you had this or a similar condition before? no yes If yes, explain _____

Has anyone in your family had a similar condition before? no yes If yes, who? _____

Past chiropractic treatment no yes When? _____ Explain _____

Have you seen any other physicians for this condition? _____

List diagnoses and describe treatment _____

Do you wear: Glasses/contacts Heel lifts Orthotics Dental night guard

Did/do you wear dental braces? no yes When? _____

Have you been treated for any other health condition by a physician in the last year? no yes If yes, explain:

Are you currently taking prescription medication? no yes If yes, what? _____

Have you ever been on frequent or prolonged antibiotic therapy (such as erythromycin, penicillin, tetracycline, etc.)?
Please describe: _____

Current non-prescription pain relievers (Alleve, Tylenol, Aspirin, Ibuprofen, etc.). How many per day?

Other current non-prescription medications (laxatives, antihistamines, decongestants, stimulants, etc.):

Are you currently taking any vitamins or supplements? no yes If yes, what? _____

Allergies or sensitivities to drugs, foods, pollens, chemicals, animals, etc. _____

HABITS OF DAILY LIVING

Exercise: None Moderate Heavy • <1 per week 1-3 times per week Daily • Hours/ week _____

Work Activity (check all that apply): Sitting Standing Walking Light Labor Heavy Labor

Stress level: High Moderate Low • Do you do any stress reduction or relaxation activities such as meditation, yoga, prayer, etc.? _____

Are you currently on psychotropic medication or receiving psychological counseling? Please describe:

What are your favorite hobbies or other life interests? _____

Sleep habits: Hours per night _____ Restless or restful? _____ Do you dream? _____

What time do you go to bed? _____ Do you sleep through the night? _____

Alcohol consumption: Drinks per week _____ Have you ever felt the need to cut down? _____

Tobacco consumption: Do you smoke? _____ How much per day? _____ How long? _____

Did you ever smoke? _____ How much for how long? _____ When did you stop? _____

Non-medical drug use: Type and frequency _____

Chemical exposure: Do you regularly use: Cosmetics Perfumes Aftershaves Scented soaps/products

Do you have amalgam dental fillings? yes no • Any prolonged exposure to paints or solvents? yes no

Other known notable chemical exposures: _____

Diet: Do you eat regular meals? yes no • Do you sit down for meals? yes no • Do you normally eat or drink between meals? yes no What? _____

How often does your diet consist mainly of some or all of the following: salads, whole grains, eggs, fresh fruits and vegetables, lean meats, beans or legumes? rarely sometimes often almost always

Are you a vegetarian? yes no • Do you eat processed foods with artificial colorings, flavorings or preservatives (e.g. bologna, sausage, cheese spreads, baked goods)? rarely sometimes often

Do you eat "fast food"? rarely sometimes often What and how often? _____

Do you add sugar to coffee, tea, cereals, other foods? yes no • Do you use artificial sweeteners? yes no

How many servings of:

___ Fruit/day	___ Fish/week	___ Water/day	___ Tea/day
___ Vegetables/day	___ Fowl/week	___ Soft Drinks/day	___ Chocolate/Cocoa/day
___ Sweets/day	___ Red meat/week	___ Coffee/day	___ Cow dairy/day
___ Wheat (bread etc.)/day			(cheese, milk, yogurt)

GENERAL HEALTH HISTORY

List any major accidents, serious falls or injuries (with dates) _____

Broken bones, cranial injuries _____

List surgeries/hospitalizations (with dates) _____

List X-rays or special imaging taken in the last 10 years and their dates _____

Please check all that you have or have had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Grave's Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hashimoto's Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis/Bowel Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Autism | <input type="checkbox"/> COVID-19 | |

Have you ever lived or traveled outside of the United States? yes no • Had travelers diarrhea? yes no

Have you ever been tested for intestinal parasites? yes no • Been treated for intestinal parasites? yes no

If yes, please describe when, and what parasite(s) _____

CHILDHOOD HISTORY

Were you adopted? _____ If so, at what age? _____ Were you breast or bottle fed? _____

Vaginal birth or C-section? _____ Complications? _____

Childhood illnesses:

- | | | | |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Recurrent Colds | <input type="checkbox"/> Colic | <input type="checkbox"/> Mumps | <input type="checkbox"/> Frequent Antibiotics
number of times ____ |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Persistent Diaper Rashes | <input type="checkbox"/> Rubella | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Chicken Pox | |

Was your home life (check all that apply):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Loving | <input type="checkbox"/> Fun | <input type="checkbox"/> Loud | <input type="checkbox"/> Alcoholic |
| <input type="checkbox"/> Supportive | <input type="checkbox"/> Educational | <input type="checkbox"/> Argumentative | <input type="checkbox"/> Physically Abusive |
| <input type="checkbox"/> Peaceful | <input type="checkbox"/> Stressful | <input type="checkbox"/> Single Parent | <input type="checkbox"/> Verbally Abusive |
| <input type="checkbox"/> Filled with positive
extended family | <input type="checkbox"/> Financially Stressed | <input type="checkbox"/> Lonely or Neglectful | <input type="checkbox"/> Sexually Abusive |

Comments: _____

FAMILY HISTORY

	Diabetes	Heart Disease/High Blood Pressure	Cancer	Musculoskeletal Problems	Other _____
Grandparent(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of siblings _____ Sibling age(s) and health status _____

Age of biological parents _____ If deceased, age and cause: _____

SYSTEMS REVIEW

Please write: C = Constantly in the present O = Occasionally in the present P = In the past

<p>GENERAL</p> <p>_____ Allergies</p> <p>_____ Chills</p> <p>_____ Convulsions</p> <p>_____ Dizziness</p> <p>_____ Fainting</p> <p>_____ Fatigue</p> <p>_____ Fever</p> <p>_____ Headache</p> <p>_____ Loss of Sleep</p> <p>_____ Nervousness</p> <p>_____ Night Sweats</p> <p>_____ Thirst Abnormal</p> <p>_____ Weight Loss</p> <p>_____ Weight Gain</p> <p>GASTRO-INTESTINAL</p> <p>_____ Belching or gas</p> <p>_____ Colon trouble</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Excessive hunger</p> <p>_____ Gall bladder trouble</p> <p>_____ Hemorrhoids (piles)</p> <p>_____ Intestinal parasites</p> <p>_____ Jaundice</p> <p>_____ Liver trouble</p> <p>_____ Nausea</p> <p>_____ Pain over stomach</p> <p>_____ Poor appetite</p> <p>_____ Poor digestion</p> <p>_____ Vomiting</p> <p>THYROID</p> <p>_____ Overactive</p> <p>_____ Underactive</p> <p>_____ Enlarged</p>	<p>MUSCLES & JOINTS</p> <p>_____ Arthritis</p> <p>_____ Bursitis</p> <p>_____ Hernia</p> <p>_____ Leg cramps when walking</p> <p>_____ Low back pain</p> <p>_____ Musculoskeletal birth defects</p> <p>_____ Neck pain or stiffness</p> <p>Pain, numbness or tingling in:</p> <p>_____ Shoulders</p> <p>_____ Arms</p> <p>_____ Elbows</p> <p>_____ Hands</p> <p>_____ Hips</p> <p>_____ Legs</p> <p>_____ Knees</p> <p>_____ Feet</p> <p>_____ Painful tailbone</p> <p>_____ Paralysis</p> <p>_____ Poor posture</p> <p>_____ Sciatica</p> <p>_____ Stiff neck</p> <p>_____ Spinal curvature</p> <p>_____ Swollen joints</p> <p>SKIN</p> <p>_____ Boils</p> <p>_____ Bruising easily</p> <p>_____ Dryness</p> <p>_____ Eczema</p> <p>_____ Psoriasis</p> <p>_____ Hives or allergies</p> <p>_____ Itching</p> <p>_____ Sensitive skin</p> <p>_____ Skin eruptions</p>	<p>CARDIOVASCULAR</p> <p>_____ Easy Bruising</p> <p>_____ Hardening of arteries</p> <p>_____ High blood pressure</p> <p>_____ Low blood pressure</p> <p>_____ Pain over heart</p> <p>_____ Poor circulation</p> <p>_____ Rapid heart</p> <p>_____ Slow heart</p> <p>_____ Swelling ankles</p> <p>_____ Varicose veins</p> <p>EYE/EAR/NOSE/THROAT</p> <p>_____ Crossed eyes</p> <p>_____ Dry eyes</p> <p>_____ Eye pain</p> <p>_____ Farsightedness</p> <p>_____ Nearsightedness</p> <p>_____ Light sensitivity</p> <p>_____ Earache</p> <p>_____ Ear discharge</p> <p>_____ Ear noises</p> <p>_____ Hearing difficulty</p> <p>_____ Hearing sensitivity</p> <p>_____ Nasal obstruction</p> <p>_____ Nose bleeds</p> <p>_____ Sinusitis</p> <p>_____ Stuffy nose</p> <p>_____ Hay fever</p> <p>_____ Frequent colds</p> <p>_____ Hoarseness</p> <p>_____ Sore throats</p> <p>_____ Enlarged glands</p> <p>_____ Enlarged thyroid</p> <p>_____ Dental decay</p> <p>_____ Grinding teeth</p>	<p>RESPIRATORY</p> <p>_____ Asthma</p> <p>_____ Chest pain</p> <p>_____ Chronic cough</p> <p>_____ Difficulty breathing</p> <p>_____ Spitting blood</p> <p>_____ Spitting phlegm</p> <p>_____ Wheezing</p> <p>GENITO-URINARY</p> <p>_____ Bed wetting</p> <p>_____ Blood in urine</p> <p>_____ Frequent urination</p> <p>_____ Incontinence</p> <p>_____ Kidney infection</p> <p>_____ Kidney stones</p> <p>_____ Night urination</p> <p>_____ Painful urination</p> <p>_____ Prostate trouble</p> <p>FOR WOMEN ONLY</p> <p>_____ Cramps or backache</p> <p>_____ Excessive flow</p> <p>_____ Hot flashes</p> <p>_____ Irregular cycle</p> <p>_____ Lumps in breast</p> <p>_____ Miscarriage</p> <p>_____ Painful periods</p> <p>_____ PMS</p> <p>_____ Vaginal discharge</p> <p><input type="checkbox"/>Y <input type="checkbox"/>N Pregnant at this time?</p> <p>Last Pap _____</p> <p>Menstrual cycle: _____ days</p> <p>Date of last period: _____</p>
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Your completion of this Intake Form will help us determine whether our services might meet your needs. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice's services may not meet your needs, we may offer to discuss possible alternative practitioners at the Lydian Center. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether you become a patient of the Practice.

Please note that each non-chiropractic practitioner practicing at the Lydian Center owns and operates his/her own clinical practice and is not affiliated with Lydian Chiropractic. While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek your treatment and care from any practitioner at any facility you choose.

Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: